3 Home Health Guidelines

3.1 Introduction

3.1.1 General Policy

This section encompasses all Medicaid covered services provided by home health facilities as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Services and Limitations.
- Claims payment.
- Home health revenue codes, type of bill, occurrence and status codes.
- Electronic and paper claims billing.

3.1.2 Participant Eligibility

To be eligible for home health services, a participant must have a physician's order as part of a plan of care. Home health services must be medically necessary and may include nursing services, supplies, home health aide services, durable medical equipment rentals, drugs, physical therapy, occupational therapy, and speech-language pathology services.

If a person is eligible for both Medicare and Medicaid, Medicaid's payment for services will not exceed the amount allowed by Medicaid minus Medicare's payment for those services.

3.1.3 Advanced Directives

Home health service providers must explain to each participant their right to make decisions regarding their medical care. This includes the right to accept or refuse treatment. Home health care providers must inform the participant of their right to formulate advance directives, such as a Living Will or Durable Power of Attorney, before the participant is under the provider's care.

3.1.4 Prior Authorization (PA)

Home health service providers do not need to request PA for their services.

3.1.5 Payment

3.1.5.1 Customary Fees

Medicaid reimburses home health services on a per visit basis. Usual and customary fees are paid up to the Medicaid maximum allowance. All home health services must be billed by the home health provider on the UB-04 claim form using the appropriate revenue and type of bill codes. See *Section 3.2.5 Type of Bill Codes*. Physicians not employed by the home health agency must bill independently for their services.

3.1.5.2 Crossover Claims

Medicare pays for some physician-ordered services for Medicare eligible participants. Medicaid will pay at a maximum the difference between the Medicare payment and the Medicaid allowed amount or the Medicare co-insurance and/or deductible, whichever is less.

See *Section 2.5 Crossover Claims*, for more information on crossover claim submission.

3.1.5.3 Interim Payment

Interim payment is based on the lesser of the Medicaid cost caps established by DHW on a state fiscal year basis or billed amount.

- Skilled nurse visit.
- Home health aide.
- Physical therapy.
- Occupational therapy.

- Speech-language pathology services.

Final payments are the lower of reasonable costs as determined by the Medicare finalized cost report or the Medicaid cost caps.

Note: Mileage is included as part of the per-visit payment.

3.1.5.4 Evaluation Visit

Payment for the initial nursing evaluation visit depends upon the participant's need for home health services. The provider should bill according to the following requirements:

- If the participant needs further home health services, bill the evaluation visit as a skilled nursing visit.
- If the participant does not require home health services, the visit must be charged to the agency administration cost center.

3.1.5.5 Healthy Connections (HC) Referral

If the participant is enrolled in HC, Idaho Medicaid's primary care case management (PCCM) model of managed care. A HC referral is required from the participant's primary care physician (PCP) for home health services. That physician's HC referral number must be on the claim submitted by the home health agency.

3.2 Home Health Service Policy

3.2.1 Overview

Home Health Program services include physician ordered home health services delivered under a written plan of care. These include nursing services, home health aide services, physical therapy, occupational therapy, and speech-language pathology services.

3.2.2 Limits

Home health services are limited to a total of 100 medically necessary visits per participant, per calendar year.

3.2.3 Plan of Care

Federal and state Medicaid regulations require home health providers to have an established plan of care (POC) for each participant and to have each participant's plan reviewed by the attending physician every 60 days. A current POC must contain the physician's signature, dated within the required 60 day time frame. The home health agency must maintain a copy of the POC.

3.2.4 Medical Equipment and Supplies

3.2.4.1 Overview

Physician ordered medical supplies and rented medical equipment must meet the following criteria for Medicaid payment:

- Medically necessary.
- Suitable for use in the home.
- Reevaluated at least once every 60 days.

3.2.4.2 Rental Costs

The Department of Health and Welfare may arrange purchase agreements with providers to purchase medical equipment when the rental charges total more than the purchase price of the equipment. All such purchases will be handled separately from the home health program as medical vendor transactions.

3.2.4.3 Influenza Vaccinations

All routine injections are included in the home health agency scheduled visits. The exception to this rule is the administration of the influenza vaccine. The Department of Health and Welfare will reimburse the agency 'injection administration' costs if no other home health visit is billed on the same day as the vaccination. A description in the remarks section must indicate that 'influenza vaccine' was administered.

3.2.5 Type of Bill Codes

Use one of the following type of bill codes that best describes your claim:

331 Admit through Discharge

332 Interim-First Claim

333 Interim-Continuing Claim

334 Interim-Last Claim

3.2.6 Revenue Codes

All home health services must be billed using unique, 3-digit revenue codes. EDS will deny any claim with any other revenue codes entered.

Service	Rev. Code	Description
Home Health Supplies	**270**	Includes dietary products. All items must be included in the written plan of care.
Rental Durable Medical Equipment	**291**	All items must be included in the written plan of care.
Home Health Physical Therapy Visit	**421**	Must be included in the written plan of care.
Home Health Occupational Therapy Visit	**431**	Must be included in the written plan of care.
Home Health Speech-Language Pathology Visit	**441**	Must be included in the written plan of care.
Skilled Nurse Visit	**551**	Requires the skills of a registered nurse (RN) or licensed practical nurse (LPN). Must be included in the written plan of care.
Aide Visit	**571**	Services that can be adequately performed by trained nurse aides. However, they may be performed by either licensed personnel or the home health aide. Must be included in the written plan of care.
Drugs Requiring Special Coding	**771**	Use revenue code **771** and CPT/HCPCS code for the administration. Refer to Idaho Medicaid Information Release MA03-69 for more information on billing with **J** codes.

Note: Information Releases are available online at: **http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3348/DesktopDefault.aspx**

3.2.7 Occurrence Codes and Dates

Enter one of the following codes in fields **31-34** on the UB-04 claim form with the date of occurrence:

01 Auto Accident

02 Auto Accident/No Fault

03 Accident/Tort

04 Accident/Employment Related

05 Other Accident

06 Crime Victim

24 Date Insurance Denied

25 Date Benefits Terminated by Primary Carrier

42 Date of Discharge

X0 Plan of Care on file

3.2.8 Patient Status Codes

Enter the appropriate status code in field **17** on the UB-04 claim form or in the appropriate field of the electronic claim form.

01 Discharge to Home or self care

02 Transfer to Hospital

03 Transfer to Nursing Home

04 Transfer to Intermediate Care Facility

05 Discharged to Another Type of health care institution not defined elsewhere in this list

06 Discharge/Transfer to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care (Indicate in appropriate field the status or location of patient and time they left the facility).

07 Left Against Medical Advice

08 Discharged/Transferred to Home Under Care of a Home IV Provider

20 Death

30 Not Discharged, Still A Patient

40 Expired at Home

41 Expired in an Institution

42 Expired, Place Unknown

43 Discharged/transferred to a Federal Health Care Facility

3.3 Claim Form Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction

To submit claims on paper, use original red UB-04 claim forms available from local form suppliers

Note: All claims must be received within 12 months (365 days) of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See *Section 2.2.1 Electronic Claims Submission, General Billing Information,* for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional transactions.

Modifiers: On an electronic HIPAA 837 Institutional transaction, where revenue codes require a corresponding HCPCS or CPT code, up to four modifiers are allowed. (On a paper claim, only two modifiers are accepted.)

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the **TC** modifier must be submitted.

Type of Bill (TOB) Codes: Idaho Medicaid rejects all electronic transactions with type of bill (TOB) codes ending in a value of six. Electronic HIPAA 837 Institutional transactions with valid TOB codes, not covered by Idaho Medicaid, are rejected before processing.

Condition Codes: Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional transaction.

Value, Occurrence, and Occurrence Span Codes: Idaho Medicaid allows 24 value, 24 occurrence, and 24 occurrence span codes on the electronic HIPAA 837 Institutional transaction.

Diagnosis Codes: Idaho Medicaid allows 27 diagnosis codes on the electronic HIPAA 837 Institutional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required to be included on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for institutional services.

3.3.3 Guidelines for Paper Claim Forms

3.3.3.1 How to Complete the Paper Claim Form

These instructions support the completion for the UB-04 claim form. The following will speed claim processing:

- Provider numbers submitted on the paper UB-04 claim form must be the 9-digit Idaho Medicaid billing provider number; paper claims submitted with only the NPI will be returned to the provider; claims submitted with both the NPI and the Medicaid provider number will be processed using the Medicaid provider number only.
- Complete all required areas of the UB-04 claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning.
- Keep claim form clean, use correction tape to cover errors.
- A maximum of 22 line items per claim can be accepted; if the number of services performed exceeds 22 lines, prepare a new claim form and complete the required data elements; total each claim separately.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- Do not use staples or paperclips for attachments, stack them behind the claim.
- Do not fold the claim form(s), mail flat in a large envelope (recommend 9 x 12).

See *Section 3.3.3.3 Completing Specific Fields on a Paper Claim Form* for instructions on completing specific fields.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on a Paper Claim Form

See *Section 3.3.3.4 Sample Claim Form*, to see a sample UB-04 claim form with all fields numbered. Provider questions regarding institutional policy and coverage requirements are referred to *IDAPA 16.03.09 Medicaid Basic Plan Benefits.*

The following numbered items correspond to the UB-04 claim form. Consult the, Use column, to determine if information in any particular field is required and refer to the, Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Unlabeled Field	Required	Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA). **Note:** If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.
3a	PAT. CNTL #	Desired	The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of patient financial records.

Field	Field Name	Use	Description
3b	MED REC #	Desired	Medical/Health Record Number: The number assigned to the participant's medical/health record.
4	TYPE OF BILL	Required	Type of Bill: Enter the 3-digit code from the *UB-04 Manual*. Adjustment Type of Bill Codes is not appropriate when submitting services on paper claim forms for Idaho Medicaid billings. See *Section 3.2.5 Type of Bill Codes*.
6	STATEMENT COVERS PERIOD	Required	Statement Covers Period From - Through: The beginning and ending service dates of the period included on the bill. Enter as MMDDYY or MMDDCCYY **HOME HEALTH Claims**: Home Health claims must indicate the specific, From Dates in field **45** to eliminate duplicate appearing services. **Note:** These dates must be within the Occurrence Span From and To Dates. **Late or Additional Charges:** **Home Health** claims - see field **42** and **45** for information. .
8a	PATIENT NAME	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000.
8b	Unlabeled Field	Required	Patient Name: Enter the participant's name exactly as it is spelled on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
12	ADMISSION DATE	Not Required for Home Health,	Enter the month, day, and year the participant entered the facility. (This date will be the same on all submitted claims and will not necessarily be the same as the date found in field **6**. Enter as MMDDYY or MMDDCCYY
13	ADMISSION HR	Not Required, for Home Health	Enter the 2-digit hour the participant was admitted for inpatient or outpatient care in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims.
14	ADMISSION TYPE	Not Required, for Home Health	Admission Type: Use the priority admission codes in the *UB-04 Manual*. Only codes **1**, **2**, **3**, and **4** are allowed by Medicaid. Required for inpatient claims.
15	ADMISSION SRC	Not Required, for Home Health	Admission Source: Use the 1-digit source of admission codes **1** through **8** in the *UB-04 Manual*. Medicaid does not accept code **9**. Required for inpatient claims. Not Required for outpatient claims.
16	DHR	Not Required, for Home Health	Discharge Hour: Enter the 2-digit hour the participant was discharged in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims. Desired for outpatient claims.

Field	Field Name	Use	Description
17	STAT	Not required for Home Health	Patient Status: Use one of the codes listed in *Section 3.2.8 Patient Status Codes*, to indicate patient status. Required for inpatient claims. Not Required for outpatient claims.
18-28	CONDITION CODES	Desired	Use the codes listed in the NUBC billing manual. **NOTE:** If the participant has Medicare and Home Health services are, Not Homebound – use Condition Code 12.
31-34	OCCURRENCE CODE/DATE	Required	Use the code **X0 ('0' is zero)** listed in *Section 3.2.7 Occurrence, Codes and Dates* of the billing manual and enter the date of the occurrence.
35-36	OCCURRENCE SPAN	Required	Use the date span related to the, Occurrence Code X0, entered in the preceding field. **Note:** Occurrence Span dates indicate the dates of the physician signed plan of care. The, Statement Covers Period, must be the same as or within the occurrence span dates.
39-41	VALUE CODES AMOUNT	Not Required, for Home Health	Value Codes and Amounts: **Covered Days:** **Required for inpatient claims only** **80** – Covered Days **81** – Co-Insurance days (Cross over claims only) **82** – Lifetime Reserve Days (Cross over claims only)
42	REV. CD.	Required	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. See *Section 3.2.6 Revenue Codes*. **Revenue code 001** is no longer to be used for the total charges; the total charges are to be entered in the designated box on line **23**. **Home Health claims (late, additional, or denied charges):** 1. Late or additional charges where the revenue code was not on the original claim: Bill on a new claim for only the late or additional charges with the revenue code**.** Note in the field **80**, *Billing for Late Charges*. 2. Late or additional charges where the revenue code was paid on the original claim: Submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: Bill the denied line with the revenue code on a new claim. Note in the field **80**, *Billing for Denied Lines*.
44	HCPCS/RATE/ HIPPS CODE	Required, If Applicable	CPT/HCPCS/MODIFIERS/RATES: All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with CPT or HCPCS notation in *Section 3.2.6 Revenue Codes*. If the code requires a modifier, put one space between the code and modifier. **Example:** Revenue code 771 requires a corresponding immunization or immunization administration CPT/HCPCS procedure , i.e. G0008 **Note:** HIPPS codes are not billable to Idaho Medicaid.

Field	Field Name	Use	Description
45	SERV. DATE	Required	Service Dates: Required for all Home Health services. Enter the specific date of service for all charges or the claims will be denied. **Home Health claims (late, additional, or denied charges):** 1. Late or additional charges outside the date span in field **6**: bill on a new claim form. Note in the field **80**, *Billing for Late Charges*. 2. Late or additional charges within the date span in field **6** with the same revenue codes and the same specific date: submit on an adjustment request form. 3. Late or additional charges within the date span in field **6** with different revenue codes: bill on a new claim form. Note in the field **80**, *Billing for Late Charges*. 4. Resubmit all denied charges on a new claim.
46	SERV. UNITS	Required	Enter the total number of units of service or visits for each revenue code for each date of service.
47	TOTAL CHARGES	Required	Total charges: Bill total covered charges only. Ancillary Charges Formula: Revenue Code Fee X Units of Service Total Charges
In fields **50** through **62**, each field has three lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one other payer in addition to Medicaid, enter all primary payer data on line A and all Medicaid data on line B. If there are two other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer data on line B, and all Medicaid data on line C.			
50 A-C	PAYER NAME	Not Required	Payer A: If Medicaid is the only payer, enter, Idaho Medicaid in field **50A**. If there is one other payer in addition to Medicaid, enter the name of the group or plan in field **50A** and enter, Idaho Medicaid in field **50B**.
51 A-C	HEALTH PLAN ID	Not Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in field **50 A-C**. Example: In field **50A**, Medicare is entered as the Payer. In field **51A**, enter the identification number used by Medicare for the provider. Example: In field **50B**, Healthy Home Insurance Company is entered as the Payer. In field **51B** enter the identification number used by Healthy Home Insurance Company for the provider.
54	PRIOR PAYMENTS	Required, If Applicable	Prior Payments - Payers and Participant: Required if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do not include previous Medicaid payments.
55	EST. AMOUNT DUE	Not Required	Estimated Amount Due: Total charges due (total from field **47**) minus prior payments (total from field **54**).
57 A-C	OTHER (BILLING) PRV ID	Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in field **50 A-C**. Example: In field **50A**, Medicare is entered as the Payer. In field **57A**, enter the identification number used by Medicare for the provider. Example: In field **50B**, Healthy Home Insurance Company is entered as the Payer. In field **57B** enter the identification number used by Healthy Home Insurance Company for the provider.

Field	Field Name	Use	Description
58	INSURED'S NAME	Desired	Insured's Name: If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial. Enter the participant Medicaid data in the same line used to enter the Medicaid provider data. Example: Medicaid provider information is entered in **50A**, and then the Medicaid participant data must be entered in **58A**.
59	P. REL	Desired	Patient's Relationship to Insured: See the *UB-04 Manual* for the 2-digit relationship codes.
60	INSURED'S UNIQUE ID	Not Required	Participant Identification Number: Enter the 7-digit MID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. This is the default field if the 7-digit MID number is not entered in field 8a. Example: 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).
61	GROUP NAME	Not Required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	INSURANCE GROUP NO.	Not Required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORIZ-ATION CODES	Required, If Applicable	Treatment Authorization Codes: If billing for services that require prior authorization, enter the PA number in this field.
67 A-Q	DX	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. **Do not** use E diagnosis codes.
68-73	OTHER DX	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. **Do not** use E diagnosis codes.
69	ADMIT DX	Required	Admitting Diagnosis Code: Required for inpatient. Desired for outpatient claims. Quality Improvement Organization (QIO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the *Qualis Health Manual*.
72	ECI	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the CMS-1500 claim form for professional claims.)
74	PRINCIPAL PROCEDURE CODE/DATE	Desired	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical, diagnostic or obstetrical procedure. Procedure date is required if procedure code is used.
74 a-e	OTHER PROCEDURE CODE/DATE	Desired	Other Procedure Codes and Dates: Enter all secondary surgical, diagnostic or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.

Field	Field Name	Use	Description
76	ATTENDING	Required	Attending Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (last) box after, **76** Attending. Inpatient: Enter the Idaho Medicaid provider number for the physician attending the patient. This is the physician primarily responsible for the care of the participant from the beginning of this hospitalization. Outpatient: Enter the Idaho Medicaid provider number for the physician referring the participant to the hospital.

3.3.3.4 Sample Paper Claim Form